Nebraska Division of Behavioral Health

MQIT

March 27, 2012 / 9:00-10:00 a.m. CDT

DBH/Live Meeting

Meeting Minutes

I. Attendance *Bob Bussard*

Region I – Bonnie Lockhart, Mia Knotts
Region II – Angie Smith
Region III – Ann Tvrdik, Jen Puls
Region IV –Ginger Marr, Amy Stachura
Region V – Linda Wittmuss
Region VI – John Murphy, Stacey Brewer
Magellan – Lisa Christensen, Carl Chrisman, Don Reding, Travis Parker, Sue Minick
GAP Provider - Wanda Swanson
DBH – Sheri Dawson, Robert Bussard, Ying Wang, Meryem Ay, Carol Coussons de Reyes, Cody Meyer, Blaine Shaffer, Kelly Dick
Medicaid & Long Term Care: Lowell Sedlacek

II. Welcome *Bob Bussard & Sheri Dawson*

Bob welcomed the in person members and those calling in and introductions were made.	
Overview of agenda – no additions requested.	Handout 1
February 2012 MQIT minutes were approved - No additions or questions noted.	Handout 2

III. Question & Answer *Don Reding, Lisa Christensen, Carl Chrisman, Sheri Dawson, Bob Bussard*

- Regions that have questions for Magellan should have these to Bob Bussard by the end of day Thursday, prior to the next scheduled MQIT meeting (Robert.bussard@nebraska.gov) .
- Answers will be better addressed if Regions are able to submit their questions with examples or other details rather than generic questions.

Responses to Region 3 Questions:

- **Q: How will the authorizations be handled with the all-queue system for concurrent reviews if the provider is not able to get them called before 5 p.m.?**
- A: Concurrent reviews and reauthorizations utilize a paper based system with forms from Medicaid and NBHS. Specifically:

  For the Medicaid System:

  Adult Substance Abuse Treatment – Re-Authorization Form **-** revised 9.25.09

  MRO Re-Authorization Form - revised 9.25.09

  For NBHS Authorizations not MRO or SA Waiver services:

  Behavioral Health Authorization Modification Request Form - revised 8.4.2009

  These forms should be FAXED to Magellan between 5 and 10 days before the authorization end date. Check the Magellan website to determine if a re-authorization has been made through the TAD or Auth reports on the My Practice page.
- Q: A concern was raised by Region 3 regarding a time when a hospital was told by a Magellan Care Manager he or she would return the call that day, but the call was not received by the hospital by 4 p.m. (close to end of the day), and they had several concurrent calls. The hospital therefore was required to make a second call to the Magellan Care Manager the same day.

- A: If a provider contacted Magellan, and the Magellan Care Manager was the party responsible for calling the provider back (and for some reason was unable to that day), then the provider should be held harmless for start date on the re-authorization.
    - Provider should document the date of the initial call to Magellan, and then the Care Manager, having been contacted once, would be aware they had the re-auth pending.
    - Travis suggested that providers let the Care Manager know during the call whether they opt to be put back into the queue (process for expediting this option is being worked out). Also, when wait time on calls is long, some providers have reported they are taking advantage of time to complete other paperwork or prepare for their discussion with the Care Manager.
    - Magellan is working to expedite calls, but it might be a better option for providers to opt to return to the queue rather than leave a message for a return call.
- **Q: Does Magellan have a way of measuring the wait time between the initial call and when the caller gets to the next available Care Manager?**
- A: Yes, Magellan measures total calls and average wait time at half hour increments. The next MQIT meeting will include a discussion of this topic.
- **Q: If a consumer has been out of services for over a year, Medicaid will not authorize another PTA from the same provider. An individual spoke to Medicaid regarding this, and the person from Medicaid indicated this has always been the policy and under Chapter 30 and is not being applied. Why were providers not notified about this change in applying these criteria?**
- A: (Don) This is a question where it would have been helpful to have more information on the specific situation (e.g. the consumer in question). Ann will ask South Central who the consumer was. Perhaps something was miscommunicated during the interaction in question because there is not a Medicaid rule that would prohibit Magellan from doing an authorization such as this. Maybe other circumstances involved (e.g. Magellan can only authorize one PTA per year per consumer).
- A: (Carl) When talking about PTA, he assumes the discussion is about the H0002 or BioPsychoSocial, and if it is, Magellan authorizes addendums whenever anything changes that would alter that original PTA. In terms of doing a full PTA, they would do it if there was a break in service when there is a new provider. If someone is continually in the same treatment with the same provider, Magellan would do an addendum but would not authorize a full PTA.
- Question for Medicaid or Magellan (Sheri): There was a PTA Workgroup that was getting close to recommendations. Is there an update? Sue Mimick participated on the Workgroup but it has not yet brought the work of the Workgroup forward. Although there is awareness this needs to be done to close the loop on this.
- **Q: From South Central – Why is Medicaid denying two services in one day? This is regarding an IOP consumer who has to take additional hours off from work to get the required number of hours and therapy sessions within a week. Many times the consumers have to drive over an hour to get to IOP. It is beneficial for the consumers to be able to have a group IOP session and either the Individual or Family session on the same day. Time and distance are factors in rural Nebraska and (according to provider/Region) this hampers the consumer completing IOP.**
- A: (Ann) Provider said this was an issue with putting in the right CPT code. Providers in the region have shared the proper coding with each other.
- A: Carl referenced a provider bulletin that included the Correct Coding Initiative http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Medicaid-Nation-Correct-Coding-Initiative.html.
- **Q: How will providers follow up on the status of a peer to peer or reconsideration without an assigned Care Manager?**
- The Care Manager who originally took the case to the physician will call the provider back with the results. The original Care Manager will be responsible for handling any part of the review process.

ACTION ITEMS	PERSON RESPONSIBLE	DEADLINE
Data on total calls to queue and average wait time.	Magellan	4.20.12
Carl will identify and share with Magellan the bulletin that includes the Correct Coding Initiative.	Carl Chrisman	URL included in minutes

IV. Magellan Updates *Don Reding, Lisa Christensen, Carl Chrisman, Sheri Dawson, Bob Bussard*

Reports Discussion (Ave. Handle Time, NBHS Clinical Review, Error Report) • Beginning with this meeting the three Magellan reports will be made available each month on the Live Meeting room screen prior to the meeting and within the meeting minutes. Discussion will be limited to just one report each month, unless during the agenda review a request is made to discuss another report. • (Lisa: Average Handle Time) Most of the content of the calls are focused on inpatient and these calls will always take a little longer, which explains a slight rise in the average handle time. Also Magellan cannot split out adult calls from child calls, or Behavioral Health from Medicaid. • Error Report: The expectation when someone sends in a request is that he or she will hear back from Magellan when the request has been addressed. Therefore if someone does not hear back, the request was either not received for some reason, or it is pending. However, if a request is going to take longer than expected, Magellan will contact the requester; therefore it is a good practice for the requester to follow up with Magellan if they have not heard back within the expected time. If you have made a request for concurrent review or re-authorization please check the website Auth and TAD reports for information on revised end dates.	Handouts 3-5
Report Timeline (Nebraska Report Schedule, Current through May, 2012) (Don) Don addressed the calendar of current reports' promotion to the MagellanProvider.com web site. In May a change will be made that will affect all reports. Information for reports will be gathered late PM on the 9th rather than AM on the 7th (the current date). This will affect reports' production to the web by a couple of days. On the calendar: • Yellow represents when the Magellan reporting system is running reports (this date will change from the 7th of the month to the 9th of the month in May). • Red represents when the reports are staged for promotion to the web. • Purple represents when the reports are available on the web site.	Handout 6
MRO Yes/No Sort Grid (Don) • The handout was shared and there were no comments or questions.	Handout 7
Two Day Pre-Auth Proposal (Continuity of Care Proposal) (Carl) • Summary: Service provider two (the referred *to* provider) calls Magellan and does a clinical review to get a pended authorization for that service. When the consumer is admitted, there can be a simple call to Magellan to tell them of the admission, at which time Magellan will activate the authorization. Provider one can work with Magellan while the consumer is in treatment to get a pre-approved discharge plan. If all of the clinical information adds up to the next level of care, the Care Manager will enter that into the note, which will expedite the process more. Magellan will be talking to providers about doing this two days prior to the anticipated admission, but the two-day time period is flexible by a few days to allow for unforeseen delays in admit. • Sheri thanked Magellan: This plan is very consumer-centered with two important components for regions and providers to note: o Service provider one: discharge planning does happen on admission, and	Handout 8

○ Magellan will be asking for that discharge plan. • No objections to proposal and there was a suggestion it be published immediately.	
Change Status Updates (Magellan Priority Changes Timeline) • DBH and Magellan have been discussing changes for the past year or so. Implementation of the changes is according to priority and begins in May. Changes will be made through mid-August. This includes changes to the web site and the data extract that the Division receives. • New template with new questions will go to providers prior to mid-May. • Magellan has been working with e-BHIN so they can make changes.	Handout 9
PDF report writing errors: Don reported that he had received a note from computer staff that the report writing error for PDF files had been fixed. PDF reports should now run smoothly on the Magellan website.	

ACTION ITEMS	PERSON RESPONSIBLE	DEADLINE
The Report Timeline will be revised to address change of date for running the reports.	Don Reding	4.20.12
The Report Timeline will be revisited with the new date at April's MQIT meeting.	Heather Wood, Kelly Dick	4.24.12
Attach Priority Timeline and list of changes and dates to March minutes.	Kelly Dick	**E-mail Attachment sent with minutes**
New Magellan template to providers.	Bob Bussard	Mid-May
Attach Don's PowerPoint from previous MQIT to March minutes.	Kelly Dick	**Attachment 1**
Publish Two Day Pre-Auth Proposal (Continuity of Care Proposal).	Bob Bussard	**Attachment 2**

V. Other *Bob Bussard, Sheri Dawson, Group*

Magellan Provider Manual Feedback: • Comments requested. • Much of the confusion over drop-down boxes is addressed and clarified in the manual according to questions brought up at previous MQIT meetings (note page 41 of manual). • This current DRAFT of the manual is okay to release (e.g. at RQIT meetings, providers). • Feedback from providers and/or users of the system is still encouraged and will be incorporated into the manual. • Destroy all copies that are dated prior to March 15, 2012.
Concurrent Reviews (Carl): These are being received at (faxed to) Magellan too early (as much as two months prior to the end date). Two weeks ahead of time is best; however, 30 days ahead is also acceptable. The process is the same for DBH and Medicaid.
Update on Phase 3 Clean Up (Don): • Initial run removed 240 duplicate registrations, with an additional 80 removed later. Duplicates found in this run had to exactly meet 4 parameters (e.g. service type, admission date, etc.); therefore there may be additional duplicates that did not meet one or more of the four parameters. This was not a test.
Call for April Agenda Items: • Update SED SPMI Report • Review of MRO Yes/No

ACTION ITEMS	PERSON RESPONSIBLE	DEADLINE
Keep provider manual on agenda for April & going forward for now	Heather Wood, Kelly Dick	Ongoing
Add Manual to MQIT web page	Bob Bussard	Complete
Next steps for Phase 3 Clean Up: identify how this is related to TADs, annual reregistration and discharge compliance reports, and summarize where we are and identify next steps – on April agenda	Heather Wood, Kelly Dick	4.24.12

VI. Meeting Close *Bob Bussard*

- Next meeting: April 24, 2012, 9:00 – 10:00 a.m. CDT
- Adjourn

Minutes prepared by the Division of Behavioral Health, Nebraska Department of Human Services. Minutes are intended to provide only a general summary of the proceedings

Group 1 (Priority 2 Changes)

Change #	Description
8	• Add new field with three variables regarding CFS involvement with the member.
12	• Add new field regarding School Attendance with drop down for response choices.
16	• Add new field regarding provision of the service via Telehealth.
18	• Add new field to Admit and D/C screen regarding school attendance with drop-down and 6 response choices.
34	• Multiple revisions to NOMS reports.
35	• Multiple revisions to NBHS EPC reports.
38	• Revise Frequency of Web Reports
39	• Revise report parameters for Mental Health Board commitment information.
40	• Add out of region counties to each regions annual report. Report number of admissions and report number of persons served by county of residence.
53	• Add new question for Socioeconomic Indicators regarding job stability with drop down for response choices.
54	• Add new question for Socioeconomic Indicators regarding living situation with drop down for response choices.
55	• Add new question for Gambling History regarding Helpline with drop down for response choices.
58	• Add Level of Care drop down box for Gambling Treatment
59	• Add additional options to D/C screen pertaining to employment status as well as updates to existing options.
60	• Add new question regarding living situation with drop down for response choices on D/C screen.
61	• Add new question regarding Helpline since treatment admission with drop down for response choices.

Group 2 (Priority 3 Changes)

Change #	Description
2	• Add new fields; Feet, Inches, Pounds for Height and Weight on Admit screen.
4	• Add new field for Level of Smoking with drop down for response choices on Admit and D/C screens.
36	• One time revision to NBHS/GAP data for referral source at admission and at discharge.
50	• Add new question regarding smoking cessation with the ability to choose Y, N or NA on Admit, re-registration and D/C screens.
51	• Add two new questions regarding Quitline with the ability to choose Y, N or NA on Admit, re-registration and D/C screens.
52	• Remove Question/Answer regarding gambling from Admit screen.
56	• Add new question for Level of Social Connection for Gambling Treatment with 2 digit field or drop down for response choice.
57	• Change existing question and response field regarding Self Help/Support groups for gambling with the ability to choose Y, N.
62	• Add new question regarding Level of Social Connection for gambling with 2 digit field or drop down for response choice.

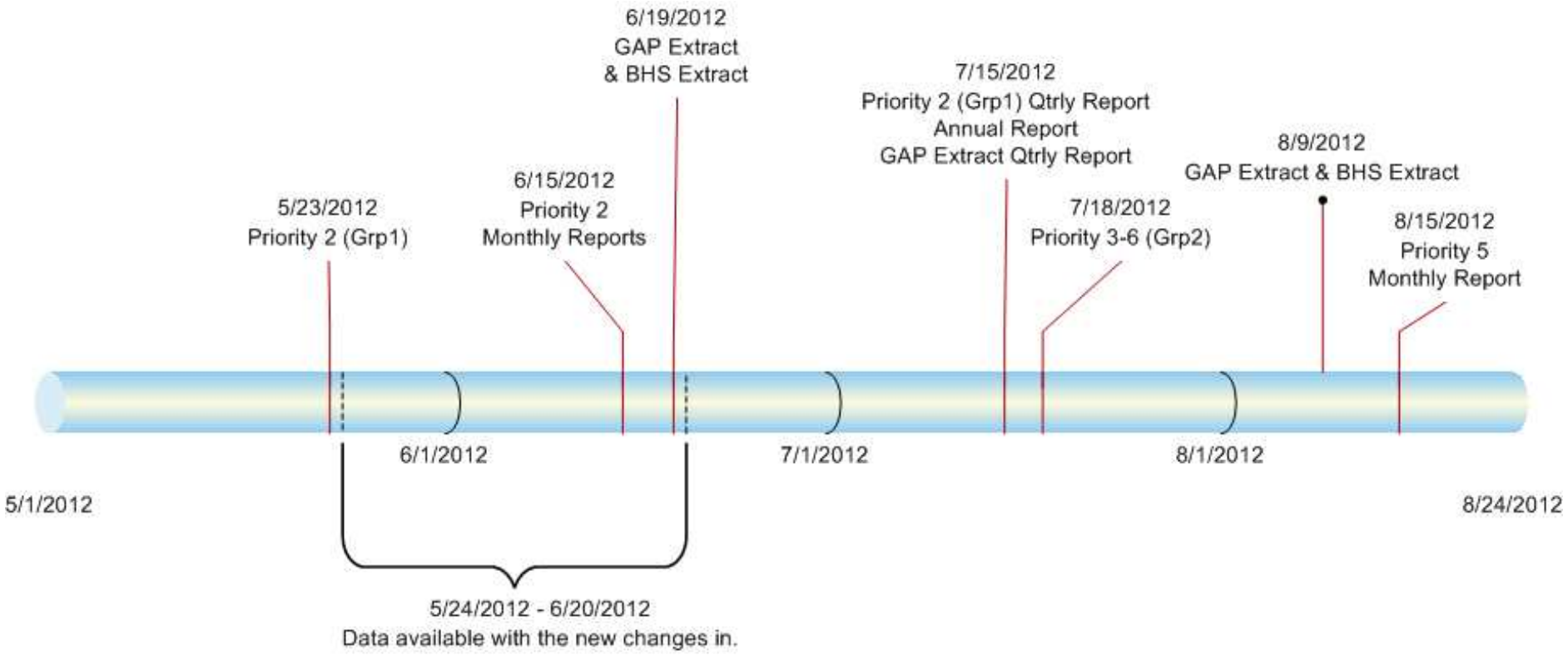
Group 2 (Priority 4 Changes)

Change #	Description
1	• Add three new 2 digit number fields for prescription drug use on Admit, Re-Registration and D/C screens.
3	• Add two new questions regarding the quality of Physical and Mental health with 2 digit number response fields.
5	• Add four new questions regarding tobacco use with drop down for response choices on Admit, re-registration and D/C screens.
6	• Add new question regarding smoking cessation with the ability to choose Y, N or NA on Admit, re-registration and D/C screens.
31	• Add new question regarding PCP with Y/N response field as well as question for date last seen with Month and Year drop down for response choices.
32	• Change Start Date & End Date calendar fields within Search Parameters in Report Program to single Month & Year drop down for response choices.
32	• Change report timeframe field within Report Parameters in Report Program to single drop down of Year and Add single Month drop down for response choice.

Group 2 (Priority 5-6 Changes)

Change #	Description
42	• Add new gender option of 'Other' to Admit, re-registration and D/C screens.
43	• Add names of providers (Medicaid and NBHS) to dual authorization report, Report ID MCOO0014A.
45	• Change Adolescents School attendance from 6 mo to 3 mo pertaining to highest grade completed or current grade level.
47	• Update re-registration and D/C screens to allow Adolescent questions to be repeated.
48	• Add additional option 'State Ward' to Admit, re-registration and D/C screen pertaining to legal status.
	• Remove destination options 'HRC' & 'NRC' on D/C screen; stop old choice going forward and only have available new choices.*

Priority 2-6 Implementation Timeline



Discharge planning begins at admission and evolves as clients improve and needs change. To facilitate a seamless transition for clients being referred from a higher level of care to a lower level of care, Magellan proposes the following workflows, regardless of payer source.

1. Service Provider One:
    - During the admission call to Magellan, the current treating provider identifies the discharge plan so the Magellan care manager can document it as approved. (This may be a level of care, not necessarily a specific after care provider.)
    - For longer stay services, the current treating provider fills out the continuing stay request form and indicates what the after care plan is and provides a brief clinical rationale. (The Magellan care manager will document the aftercare plan as approved.)
    - The current treating provider proceeds with their customary discharge procedure and forwards appropriate referral information to the referral provider.
2. Service Provider Two:
    - The receiving provider goes on-line and registers a Pre-auth for their service, if meeting admission criteria. The receiving provider calls Magellan **up to two days prior to the anticipated admission date** to their service and completes the clinical authorization process.
    - The Magellan care manager pends the authorization until the client actually admits.
    - When the client arrives for admission, the aftercare provider (or referred to provider) calls Magellan and reports their client has admitted. Magellan activates the authorization.